

(Name of Law Enforcement Agency)

AUTHORITY TO RELEASE INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize the _____ and its authorized representatives bearing this release, or a copy thereof, within one year of its date, to obtain any information in your files pertaining to my employment, military, credit, education or medical records, including not limited to academic, achievement, attendance, athletic, personal history, and disciplinary records, medical records, and credit records.

I hereby direct you to release such information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for official use. Consent is granted to all parties to furnish such information, as described above, to third parties in the course of fulfilling its official responsibilities. I hereby release you, as custodian of such records, and any school, college, university, or other educational institution, hospital, or other repository of medical records, credit bureau, lending institution, consumer reporting agency, or retail business establishment including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information, or attempt to comply with it.

I am furnishing my Social Security Account Number on a voluntary basis with the understanding such is not required by any law or regulation. I have been advised that all parties will utilize this number only to facilitate the location of employment, military, credit, and educational records concerning me in connection with this application. Should there be any question as to the validity of this release, you may contact me as indicated below:

Applicant's Printed Full Name: _____

Address: _____

Telephone Number: _____

Applicant's Notarized Signature: _____

Sworn to and signed before me, on this the _____ day of _____, _____, in and for _____ county, in the state of _____.

Signature of Notary Public: _____

NOTARY SEAL

Printed Name of Notary Public: _____

My Commission Expires: _____

Personal Health Statement

EMPLOYER _____

NAME OF EMPLOYEE and GENDER or GENDER _____
 NAME OF DEPENDENT and GENDER or GENDER _____
 NAME OF DEPENDENT and GENDER or GENDER _____
 NAME OF DEPENDENT and GENDER or GENDER _____

HEALTH INFORMATION APPLICANT MUST ANSWER EVERY QUESTION

EMPLOYEE Date of Birth _____
 Weight _____
 Your Height _____ ft. _____ in.
 EMPLOYEE'S Date of Birth _____
 SPOUSE Weight _____
 Your Height _____ ft. _____ in.

(if coverage to include spouse)

CHILDREN Name: _____ DOB: _____ Name: _____ DOB: _____
 Name: _____ DOB: _____ Name: _____ DOB: _____

Have you or any other person listed on the application in the past ten (10) years had a diagnosis of, advice for, indication of, symptoms related to, treatment for, or accident or injury related to any of the following systems, diagnoses, disorders, diseases, conditions or symptoms?

- | | |
|---|---|
| <p>A. <input type="checkbox"/> Yes <input type="checkbox"/> No Heart or circulatory system, including high blood pressure, Heart attack, chest pain, heart murmur, irregular heartbeat, varicose veins, phlebitis or poor circulation.</p> <p>B. <input type="checkbox"/> <input type="checkbox"/> Lung or respiratory system, including shortness of breath, Asthma, hay fever or other allergies, chronic cough, tuberculosis, emphysema or pneumonia</p> <p>C. <input type="checkbox"/> <input type="checkbox"/> Genito-Urinary system, including kidney stones, cystitis, Prostate, bladder infection, breast, uterus, venereal disease, C-section, complications of pregnancy, abnormal pap smear, Or menstrual disorder.</p> <p>D. <input type="checkbox"/> <input type="checkbox"/> Digestive system, including ulcer, gallbladder, gastritis Intestinal problem, colitis, hemorrhoids, hernia, pancreas, liver Or spleen</p> <p>E. <input type="checkbox"/> <input type="checkbox"/> Muscular or skeletal system, including back, joints, bones, muscles, spine, gout, arthritis or rheumatism</p> <p>F. <input type="checkbox"/> <input type="checkbox"/> The nervous system, including severe headaches, paralysis, seizures, convulsions, epilepsy, nervousness, fainting, dizziness, mental, or emotional disorders or psychiatric care</p> <p>G. <input type="checkbox"/> <input type="checkbox"/> Eye, ear, throat mouth or teeth</p> | <p>H. <input type="checkbox"/> <input type="checkbox"/> Any type of cancer, tumor, cyst or other growth, skin problem, goiter, thyroid, anemia, hemophilia or other glands, blood and blood forming organs</p> <p>I. <input type="checkbox"/> <input type="checkbox"/> Diabetes, elevated blood sugar; or blood sugar, or albumin in the urine</p> <p>J. <input type="checkbox"/> <input type="checkbox"/> Alcohol or drug dependency, overdose reaction, abuse, or counseling by Alcoholics Anonymous or similar organization.</p> <p>K. <input type="checkbox"/> <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS)</p> <p>L. <input type="checkbox"/> <input type="checkbox"/> Sudden weight loss, night sweats, persistent fever, Malaise mouth infection or lymph node enlargement</p> <p>M. <input type="checkbox"/> <input type="checkbox"/> Any other abnormality, deformity, developmental defect, abnormality, disease or disorder</p> |
|---|---|

NOTE: If you have answered Yes to any questions in this block, please indicate the question letter(s), Person's name, doctor's name and address, treatment, dates, results. Medications and any other pertinent information in the space below.

- N. Is any individual to be enrolled pregnant? Yes No
- O. Have you or any individual listed on this application seen a doctor, had surgery, been hospitalized, institutionalized, or had an accident requiring medical treatment? Yes No If yes, please explain: _____
- P. Does any individual to be enrolled take prescription drugs? Yes No If yes, list drug(s) below: _____
- Q. Do you or any person listed on the application have symptoms of, or trouble with, any physical, mental or emotional condition for which such person has not yet seen a doctor or for which treatment has been recommended? Yes No If yes, please explain: _____

CONTINUED ON BACK

R. List Doctor(s) name, address and phone number for each individual to be insured:

| Individuals To be Covered | Doctor's Name | Doctor's Address | Doctor's Phone Number |
|---------------------------|---------------|------------------|-----------------------|
|---------------------------|---------------|------------------|-----------------------|

S. Have you or any person listed ever been rejected for health coverage? Yes No If yes, please give a complete explanation:

T. Have you or any person listed been disabled or are currently disabled? Yes No Date of Disability: _____

U. Have you or any person listed ever been considered as not actively at work? Yes No

I have _____ (number) children eligible as dependent in the group policy.

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form a part of my application form for healthcare benefits and that such benefits will not become effective until such application has been approved by TML Intergovernmental Employee Benefits Pool (TMLIEBP).

MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, health benefit organization, Medicare Part A and Part B carrier, or other organization, institution or person, that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give TMLIEBP or its reinsurers any such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Exemptions from Privacy and Confidentiality include research, limited law enforcement activities, clinical and administrative proceedings, emergency circumstances, identification of a body of deceased person or cause of death, activities related to nation defense and security.

Except as noted below, we will not disclose information about you without your authorization. TML IEBP may, without your prior consent and only as permitted by law to provide information to:

- ⌘ Payment of services, including collections and subrogation
- ⌘ Reinsurance Carrier
- ⌘ TML IEBP's Business Associates
- ⌘ Eligibility Clearing House
- ⌘ Professional Healthcare Negotiations
- ⌘ Response to valid Summons, Court Orders, Search Warrant, Subpoenas
- ⌘ Prescription Benefit Manager
- ⌘ Any other entity for any other purpose allowed under 45 CFR Part 164

- I understand that any communication among the physician, patient, TML Intergovernmental Employee Benefits Pool and the Medical Management staff is confidential.
- I hereby authorize TML Intergovernmental Employee Benefits Pool to review medical records and discuss my medical condition and treatment with my physician and other health care providers.
- This consent remains in effect for as long as TML Intergovernmental Employee Benefits Pool requires the information in reviewing medical services and costs of medical services for this treatment episode, unless revoked in writing by the covered person. A photocopy of this consent is as valid as the original.

Signature of Employee or Covered Individual _____

Date: _____

APPLICANT'S CERTIFICATION AND AGREEMENT

I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge and authorize [City of Encinal] to verify their accuracy and to obtain reference information on my work performance. I hereby release [City of Encinal] from any/all liability of whatever kind and nature which, at any time, could result from obtaining and having an employment decision based on such information.

I understand that, if employed, falsified statements of any kind or omissions of facts called for on this application shall be considered sufficient basis for dismissal.

I understand that should an employment offer be extended to me and accepted that I will fully adhere to the policies, rules and regulations of employment of the Employer. However, I further understand that neither the policies, rules, regulations of employment or anything said during the interview process shall be deemed to constitute the terms of an implied employment contract. I understand that any employment offered is for an indefinite duration and at will and that either I or the Employer may terminate my employment at any time with or without notice or cause.

Signature of Applicant: _____ Date: _____

Employee Acknowledgement Form

Instructions:

1. Please carefully read all the statements below.
2. Please sign and date this Acknowledgement Form.
3. Please send one signed copy to the Human Resources Department of City of Encinal and retain one copy for your own personal records.

I ACKNOWLEDGE THAT THIS HANDBOOK, NOT WITHSTANDING ANY OTHER STATEMENT, EITHER IN THIS HANDBOOK OR ELSEWHERE, WHETHER ORAL OR WRITTEN, IS NOT A CONTRACT OF EMPLOYMENT, AND IS NOT INTENDED TO CREATE CONTRACTUAL OBLIGATIONS OF ANY KIND. I FURTHER UNDERSTAND THAT EMPLOYMENT WILL BE ON AN "AT WILL" BASIS UNLESS THERE IS A SPECIFIC WRITTEN EMPLOYMENT CONTRACT THAT PROVIDES OTHERWISE AND EITHER THE CITY OF ENCINAL OR THE EMPLOYEE MAY TERMINATE EMPLOYMENT AT ANY TIME, WITH OR WITHOUT NOTICE OR CAUSE, AND FOR ANY OR NO REASON.

IN THE HIGHLY UNLIKELY EVENT THAT THE CITY OF ENCINAL AND I ARE UNABLE TO PRIVATELY RESOLVE A DISPUTE BETWEEN US RELATING TO ANY ASPECT OF MY EMPLOYMENT; OR TERMINATION THEREOF, OR ANY PROVISION IN THIS HANDBOOK, I AGREE THAT I WILL NOT RESORT TO CIVIL LITIGATION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO READ AND COMPLY WITH THE POLICIES CONTAINED IN THIS HANDBOOK AND ANY REVISIONS MADE TO IT.

I AM ALSO AWARE THAT THE CITY OF ENCINAL WILL PERIODICALLY POST NEW POLICIES, REVISIONS, AND UPDATES TO THIS HANDBOOK.

I _____ HAVE READ AND UNDERSTAND ALL POLICIES AND PROCEDURES. I UNDERSTAND THAT I AM REPRESENTING THE CITY AND CHOOSE TO FOLLOW THE POLICIES AND PROCEDURES LISTED. I ALSO UNDERSTAND THAT IF I DO NOT FOLLOW THEM, I CAN AND WILL BE REPRIMANDED ACCORDINGLY; THE CITY HAS THE AUTHORITY TO MAKE ANY ADJUSTMENTS NECESSARY TO THE POLICIES AND PROCEDURES. IF I HAVE COMMENTS OR COMPLAINTS REGARDING THESE POLICIES I MAY USE THE SPACE BELOW TO MAKE THEM.

Employee Signature _____ Date _____

Print Name _____

EMPLOYEE COMMENTS:

Acknowledgement of Receipt of Employee Handbook

The employee handbook contains information about The City of Encinal, and I understand that I should consult the City Manager/Mayor regarding any questions not answered in the handbook. I have entered into my employment relationship with The City of Encinal voluntarily, and understand that there is no specific length of employment. According, either The City of Encinal or I can terminate the relationship at will (under State of Texas law), at any time, with or without cause, and with or without advance notice.

I understand and agree that no person other than the City Manager/Mayor may enter into an employment agreement for any specific period of time, or make any agreement contrary to The City of Encinal stated employment-at-will policy.

Since the information, policies, and benefits described herein are subject to change at any time, I acknowledge that revisions to the handbook may occur, except to The City of Encinal policy of employment-at-will. All such changes will generally be communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies. Only the City Manager/Mayor has the ability to adopt any revisions to the policies in the handbook.

Furthermore, I understand that this handbook is neither a contract of employment nor a legally-binding agreement. I have had an opportunity to read the handbook, and I understand that I may ask my supervisor or any employee of the Human Resources Department any questions I might have concerning the handbook. I accept the terms of the handbook. I also understand that it is my responsibility to comply with the policies contained in this handbook, and any revisions made to it. I further agree that I remain with The City of Encinal following any modifications to the handbook; I thereby accept and agree to such changes.

I have received a copy of The City of Encinal Employee Handbook on the date listed below. I understand that I am excepting to read the entire handbook. Additionally, I will sign the two copies of this Acknowledgment of The City of Encinal representative listed below on the date specific. I understand that this form will be retained in my personal file.

Signature of Employee

Date

Employee's Name - Printed

Company Representative

Date

Dress Code and Cell Phone Policy

Cell Phones:

City of Encinal Staff may not bring their cell phones into the City Hall during working hours unless they are being used for approved City business either by the City Manager, Mayor or Office Manager.

To All City of Encinal Employees:

No Social Media during working hours unless authorized by your immediate Supervisor!

Dress Code:

Dress Code please remember:

Allowed:

City Staff:

City Logo Shirt

Khaki or Black pants

Jeans are allowed only on Thursdays unless otherwise approved

Police Dept.:

Uniforms authorized by Police Chief

Uniforms must be cleaned and maintained, and the individual must be well groomed

Not Allowed:

- No spaghetti straps, tank tops, halter tops, and no see thru tops.
- No pajama bottoms as pants
- No hats, caps, bandannas, do-rags, etc.
- No shirts with lewd, offensive, vulgar, or obscene words or pictures; cannot advertise or depict tobacco products, political positions, alcoholic beverages, drugs, or any other substance prohibited under FNCF (Legal)

Approved: September 26, 2017



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9

OMB No. 1615-0047
Expires 03/31/2016

▶ START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

| | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--------------|----------------|---------------------------|----------|--|--|--|--|--|----------------|--|--|------------------|--|
| Section 1. Employee Information and Attestation <i>(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)</i> | | | | | | | | | | | | | | | | |
| Last Name (Family Name) | | First Name (Given Name) | | Middle Initial | Other Names Used (if any) | | | | | | | | | | | |
| Address (Street Number and Name) | | Apt. Number | City or Town | | State | Zip Code | | | | | | | | | | |
| Date of Birth (mm/dd/yyyy) | U.S. Social Security Number <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | | | | | | | | E-mail Address | | | Telephone Number | |
| | | | | | | | | | | | | | | | | |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States *(See instructions)*
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

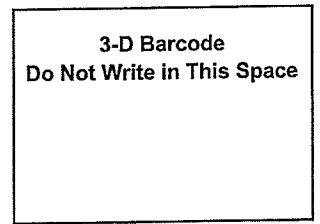
2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*



| | |
|------------------------|--------------------|
| Signature of Employee: | Date (mm/dd/yyyy): |
|------------------------|--------------------|

| |
|---|
| Preparer and/or Translator Certification <i>(To be completed and signed if Section 1 is prepared by a person other than the employee.)</i> |
|---|

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

| | | | | |
|--------------------------------------|--|-------------------------|-----------|----------|
| Signature of Preparer or Translator: | | Date (mm/dd/yyyy): | | |
| Last Name (Family Name) | | First Name (Given Name) | | |
| Address (Street Number and Name) | | City or Town | State | Zip Code |



Employer Completes Next Page



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

| List A Identity and Employment Authorization | OR | List B Identity | AND | List C Employment Authorization |
|---|----|---|-----|---------------------------------------|
| Document Title: | | Document Title: | | Document Title: |
| Issuing Authority: | | Issuing Authority: | | Issuing Authority: |
| Document Number: | | Document Number: | | Document Number: |
| Expiration Date (if any)(mm/dd/yyyy): | | Expiration Date (if any)(mm/dd/yyyy): | | Expiration Date (if any)(mm/dd/yyyy): |
| Document Title: | | <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> 3-D Barcode Do Not Write in This Space </div> | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date (if any)(mm/dd/yyyy): | | | | |

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions.)

| | | | | | |
|--|--|-------------------------|--|-------|----------|
| Signature of Employer or Authorized Representative | | Date (mm/dd/yyyy) | Title of Employer or Authorized Representative | | |
| Last Name (Family Name) | | First Name (Given Name) | Employer's Business or Organization Name | | |
| Employer's Business or Organization Address (Street Number and Name) | | | City or Town | State | Zip Code |

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

| | |
|--|---|
| A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial | B. Date of Rehire (if applicable) (mm/dd/yyyy): |
|--|---|

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

| | | |
|-----------------|------------------|---------------------------------------|
| Document Title: | Document Number: | Expiration Date (if any)(mm/dd/yyyy): |
|-----------------|------------------|---------------------------------------|

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

| | | |
|---|--------------------|--|
| Signature of Employer or Authorized Representative: | Date (mm/dd/yyyy): | Print Name of Employer or Authorized Representative: |
|---|--------------------|--|



THE STATE OF TEXAS APPLICATION FOR EMPLOYMENT

For State Agency Use Only

| |
|---------------------|
| Date received _____ |
| Time received _____ |
| Received by _____ |

Job Applicant No. _____

PRINT IN BLACK INK OR TYPE. These instructions must be followed exactly. Fill out application form completely. If questions are not applicable, enter "NA." **Do not leave questions blank.** Be sure to sign when completed. The State of Texas is an Equal Opportunity Employer and does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services. You may make copies of this application and enter different position titles, but **each copy must be signed.** Resumes will not be accepted in lieu of applications, unless specifically stated in the job vacancy notice. This application becomes public record and is subject to disclosure.

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Reference: Government Code, Sections 552.021, 552.023 and 559.004.)

NAME _____ () _____
 (Last) (First) (Middle) (Daytime Phone)

MAILING ADDRESS _____ () _____
 (Street) (City) (State) (Zip) (Country) (Work Phone, Optional)

E-MAIL ADDRESS _____

List any other names used if different from name on this application. _____

| | | |
|--|---|--------------|
| List exact title of position or type of work and location for which you wish to apply: | Job Posting Number | Closing Date |
| List the state agency with which you wish to apply: | Do you have any relatives working for this agency? If so, list names and relationships: | |

Full-Time Part-Time Summer Temp/Project Date available for work? _____ Are you at least 17 years of age? Yes No

Are you willing to work hours other than 8-5? Yes No What days are you unable to work? _____

Are you willing to travel? Yes No If yes, what percent of time? _____

Current Driver's License # (if required for position) _____ Commercial Driver's License Yes No
 (State) (Number)

Geographic preference. (Be specific to city/area. If no preference, write "statewide.") _____

Have you ever been convicted of a felony or subjected to deferred adjudication on a felony charge? Yes No If your answer is "Yes," explain in concise detail on a separate page, giving dates and nature of the offense, name and location of the court, and disposition of the case(s). A conviction may not disqualify you, but a false statement will. Note: Some state agencies may require additional information related to convictions of misdemeanors.

EDUCATION (NOTE: Applicants may be required to provide proof of diploma, degree, transcripts, licenses, certifications, and registrations.)

High School Graduate or GED? Yes No If yes, name and location of high school or GED institute: _____

| Type of School | Name and Location of School | Dates Attended | | | | Date Graduated | Expected Graduation Date | Sem/Clock Hours Completed | Type of Diploma or Degree | Major/Minor Fields of Study |
|--|-----------------------------|----------------|-----|-----|-----|----------------|--------------------------|---------------------------|---------------------------|-----------------------------|
| | | From | | To | | | | | | |
| | | Mo. | Yr. | Mo. | Yr. | | | | | |
| Undergraduate Colleges or Universities | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Graduate Schools | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Technical or Vocational Schools | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

AN EQUAL OPPORTUNITY EMPLOYER

If a license, certificate, or other authorization is required or related to the position for which you are applying, complete the following:

| LICENSE/CERTIFICATION (P.E., R.N., Attorney, C.P.A., etc.) | Date issued | Date expires | Issued by/Location of issuing authority (State or other authority) (City & State) | License No. |
|---|-------------|--------------|--|-------------|
| | | | | |
| | | | | |

Special Training/Skills/Qualifications: List all job related training or skills you possess and machines or office equipment you can use, such as calculators, printing or graphics equipment, computer equipment, types of software and hardware. (Attach additional page, if necessary.)

Approximately how many words per minute do you type? _____

Sign Language (If required for this position) Yes No

Are you a certified interpreter? Yes No

Do you speak a language other than English? (If required for this position) Yes No

How fluently? Fair Good Excellent

If yes, what language(s) do you speak? _____

Do you write in a language other than English? (If required for this position) Yes No

If yes, which language(s) _____

Have you ever been employed by the State of Texas? Yes No

Are you currently employed by the State of Texas? Yes No

If you have been previously employed by the State of Texas, list the agency/agencies: _____

FORMER FOSTER YOUTH (Verification may be required.)

Were you a foster youth under the Texas Department of Family and Protective Services on the day before your 18th birthday? Yes No
 If yes, are you currently 25 years of age or younger? Yes No

MILITARY SERVICE (A copy of a report of separation from the Armed Services may be required.)

Are you a veteran? Yes No If yes, list type of discharge _____

Dates of Service (From/To): _____

Are you a surviving spouse of a veteran who has not remarried? Yes No

Are you a surviving orphan of a veteran? Yes No

If yes, complete dates of service for veteran _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE YOUR UNDERSTANDING AND ACCEPTANCE BY SIGNING IN THE SPACE PROVIDED

- I certify that all the information provided by me in connection with my application, whether on this document or not, is true and complete, and I understand that any misstatement, falsification, or omission of information may be grounds for refusal to hire or, if hired, termination.
- I understand that as a condition of employment, I will be required to provide legal proof of authorization to work in the U.S.
- I understand that the State of Texas requires all males who are 18 through 25 and required to register with the Selective Service, to present either proof of registration or exemption from registration upon hire.
- I understand that some state agencies will check with the Texas Department of Public Safety, the Federal Bureau of Investigation or other organizations, for any criminal history in accordance with applicable statutes.
- I authorize any of the persons or organizations referenced in this application to give you any and all information concerning my previous employment, education, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application, and I release all such parties from all liability from any damages which may result from furnishing such information to you.

THIS APPLICATION MUST BE SIGNED SIGN HERE:

X

Signature – Applicant

Date

APPLICANT EEO DATA FORM

For State Agency Use Only:

Applicant Number: _____

The information requested is optional and is being collected for the purpose of reporting to Federal and Equal Employment Opportunity Agencies and will not be considered as part of the application for employment. It will be separated from the application.

| | | | | | |
|--|--|--|---|---|--|
| 1. Job Posting Number | 2. Last Name (Type or Print) | | | | |
| | First | Middle | | | |
| 3. Address | City | State | ZIP Code | 4. Daytime Phone () | 5. Work Phone () |
| 6. Sex <input type="checkbox"/> M-Male <input type="checkbox"/> F-Female | 7. Birth Date | 8. Ethnic Origin | | | |
| | | <input type="checkbox"/> W-White | <input type="checkbox"/> B-Black | <input type="checkbox"/> H-Hispanic | Asian/Pac. <input type="checkbox"/> P-Islander |
| | | | | Am. Ind/ <input type="checkbox"/> I-Alaskan | <input type="checkbox"/> O-Other |
| 9. Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Surviving Spouse of Veteran who has not remarried <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Orphan of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Former Texas Foster Youth 25 yrs of age or younger <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

13. How did you first find out about this job?

- | | | |
|--|---|--|
| <input type="checkbox"/> 01 - Other State Employee | <input type="checkbox"/> 06 - Newspaper _____ <small>Name of Newspaper</small> | <input type="checkbox"/> 11 - WorkInTexas.com |
| <input type="checkbox"/> 02 - Job Fair | <input type="checkbox"/> 07 - College/University Career Day | <input type="checkbox"/> 12 - Other (specify): _____ |
| <input type="checkbox"/> 03 - Professional Publication | <input type="checkbox"/> 08 - Human Resource/Personnel Office | |
| <input type="checkbox"/> 04 - Recruitment Poster | <input type="checkbox"/> 09 - Radio | |
| <input type="checkbox"/> 05 - Television | <input type="checkbox"/> 10 - Agency Web Site - Internet | |

X

Signature – Applicant

Date

White (Not of Hispanic origin) – All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Black (Not of Hispanic origin) – All persons having origins in any of the Black racial groups of Africa.

Hispanic – All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Asian or Pacific Islander – All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

American Indian or Alaskan Native – All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

AN EQUAL OPPORTUNITY EMPLOYER



701 Berry St/P.O. Box 120
 Encinal, Tx 78019
 Office: 956-948-5226
 Fax: 956-948-5571

**PLEASE PRINT ALL
 INFORMATION REQUESTED
 EXCEPT SIGNATURE**

City of Encinal

APPLICATION FOR EMPLOYMENT

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS

PLEASE COMPLETE PAGES 1-4. DATE _____

Name _____
Last First Middle Maiden

Present address _____
Number Street City State Zip

How long _____ Social Security No. _____ - _____ - _____

Telephone (____) _____

If under 18, please list age _____

Position applied for (1) _____
 and salary desired (2) _____
 (Be specific)

Days/hours available to work
 No Pref _____ Thur _____
 Mon _____ Fri _____
 Tue _____ Sat _____
 Wed _____ Sun _____

How many hours can you work weekly? _____ Can you work nights? _____

Employment desired FULL-TIME ONLY PART-TIME ONLY FULL- OR PART-TIME

When available for work? _____

| TYPE OF SCHOOL | NAME OF SCHOOL | LOCATION (Complete mailing address) | NUMBER OF YEARS COMPLETED | MAJOR & DEGREE |
|----------------------|----------------|--|---------------------------|----------------|
| High School | | | | |
| College | | | | |
| Bus. or Trade School | | | | |
| Professional School | | | | |

HAVE YOU EVER BEEN CONVICTED OF A CRIME? No Yes

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation. _____

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APPLICATION FOR EMPLOYMENT

MILITARY

HAVE YOU EVER BEEN IN THE ARMED FORCES? Yes No

ARE YOU NOW A MEMBER OF THE NATIONAL GUARD? Yes No

Specialty _____ Date Entered _____ Discharge Date _____

Work Experience Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

| | | | |
|--|-------------------------|------------------|---------------|
| Name of employer Address City, State, Zip Code Phone number | Name of last supervisor | Employment dates | Pay or salary |
| | | From | Start |
| | | To | Final |
| Your last job title | | | |

Reason for leaving (be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

| | | | |
|--|-------------------------|------------------|---------------|
| Name of employer Address City, State, Zip Code Phone number | Name of last supervisor | Employment dates | Pay or salary |
| | | From | Start |
| | | To | Final |
| Your Last Job Title | | | |

Reason for leaving (be specific)

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

**PLEASE PRINT ALL
INFORMATION REQUESTED
EXCEPT SIGNATURE**

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APPLICATION FOR EMPLOYMENT

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| | | | |
|--|-------------------------|------------------|----------------|
| Name of employer Address City, State, Zip Code Phone number | Name of last supervisor | Employment dates | Pay or salary |
| | | From To | Start Final |
| | Your last job title | | |
| Reason for leaving (be specific) | | | |
| List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company. | | | |

May we contact your present employer? Yes No

Did you complete this application yourself Yes No

If not, who did? _____